PEEHIP REV
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RETIREE EMPLOYMENT VERIFICATION

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa.state.al.us

PEEHIP SUBSCRIBER INFORMATION

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Home Phone	

EMPLOYMENT INFORMATION

Are you employed? ☐ Yes ☐ No If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Current Employer	Employer's Phone ____-____-____	Employment Hire Date ____/____/____

Employer's Address	City	State	ZIP Code

Does your employer offer group health insurance? ☐ Yes ☐ No

If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Does your employer contribute at least 50% or more of the cost of single health insurance coverage for its employees? ☐ Yes ☐ No

If no, go to the Medicare Information section below. Sign and date the form and return it to the address above.

Are you eligible for your employer's group health insurance coverage? ☐ Yes ☐ No

If no, please explain why not. _____

_____

_____

MEDICARE INFORMATION

This section must be completed if you or your dependents are eligible for Medicare.

Name	Medicare Card Number	Eligible for Medicare Part: ☐ A ☐ B ☐ D*	Effective Date _____/_____/_____
Name	Medicare Card Number	Eligible for Medicare Part: ☐ A ☐ B ☐ D*	Effective Date _____/_____/_____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

PEEHIP SUBSCRIBER CERTIFICATION

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all representations made by me on this form are true and complete. I understand that any misrepresentations may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation.

Retiree Signature _____ Date Signed ____/____/____

Sign, date and return the form to the address above.